

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased has been signed by the attending physician and completely filled in by the physician or attending physician. After this certificate has been signed by the attending physician and completely filled in by the physician or attending physician, it may be retained by the hospital or attending physician. If either of these persons dies before the certificate can be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

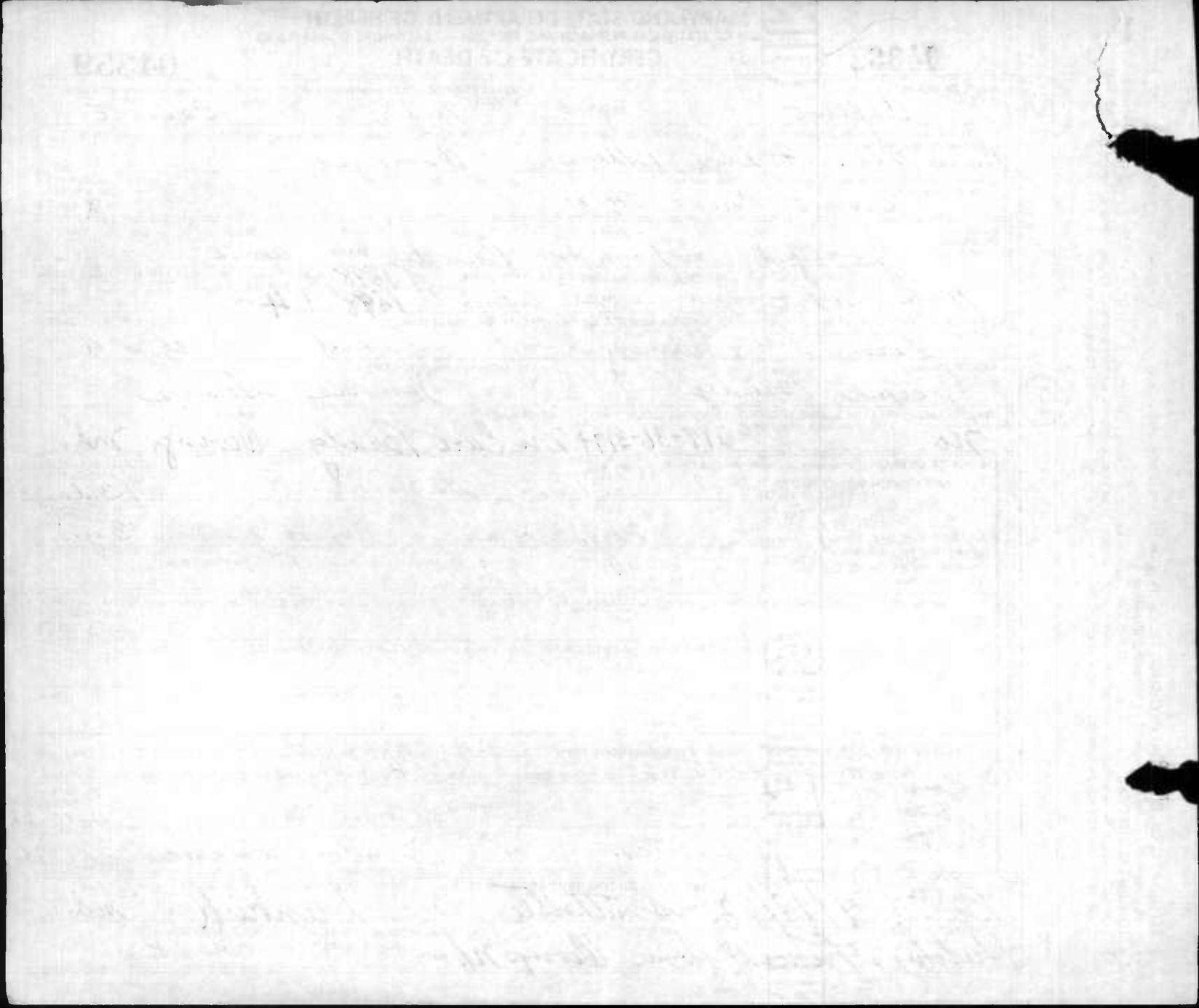
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04363

04359

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>12 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Joseph</i>	Middle <i>Thomas</i>	Last <i>Brady</i>
4. DATE OF DEATH Month <i>April</i>	Month <i>17</i>	Day <i>1962</i>	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1898</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Joseph Brady</i>	14. MOTHER'S MAIDEN NAME <i>Jennie Sears</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>218-36-3179</i>	17. INFORMANT <i>Mrs Earl Brady</i>	Address <i>Owings Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>44 BX</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Thrombosis</i>			
DUE TO (c) <i>Hypertensive Cardio- vascular Disease</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>13 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4-4 1962</i> to <i>4-16 1962</i> , that (I) (we) last saw the deceased alive on <i>4-16 1962</i> and that death occurred at <i>5 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Page C. Jett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Page C. Jett</i>		22d. ADDRESS <i>Prince Frederick, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/19/62</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>Smithville</i>		23d. LOCATION (City, town, or county) <i>Sunkirk</i> (State) <i>Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Hutchins Funeral Home Owings Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 18 '62</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04364

04360

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. CITY Arehart Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head		d. STREET ADDRESS 45 Mattingley Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	Last name Elsebough	First name Fannie	Middle name S.	4. DATE OF DEATH	Month April	Day 14	Year 1962
S. SEX	6. COLOR OR RACE Female	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 13, 1874	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Orsborn C. Lane				14. MOTHER'S MAIDEN NAME Fannie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Yes (Unknown) John L. Kierman, Indian Head, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 331 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 10 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr. 14, 1962 , to Apr. 14, 1962 , that (I) (we) last saw the deceased alive on Apr. 13, 1962 and that death occurred at 6 PM , from the causes and on the date stated above.							
22o. SIGNATURE David N. Robt				M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Apr. 14, 1962		
22c. PHYSICIAN'S NAME (Type) DAVID N. ROBERT				22d. ADDRESS % Page C. Jetton Prince Frederick Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/18/1962		23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Cemetery		23d. LOCATION (City, town, or county) (State) Jamacia, New York	
24. FUNERAL DIRECTOR'S SIGNATURE Arehart Funeral Home, Inc.				ADDRESS Arrehart Funeral Home, Inc. La Plata, Maryland		25a. REC'D BY REGISTRAR DATE APR 18 '62	
						25b. REGISTRAR'S SIGNATURE Arthur S. Knapp	

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FOR STATE
HEALTH DEPT.

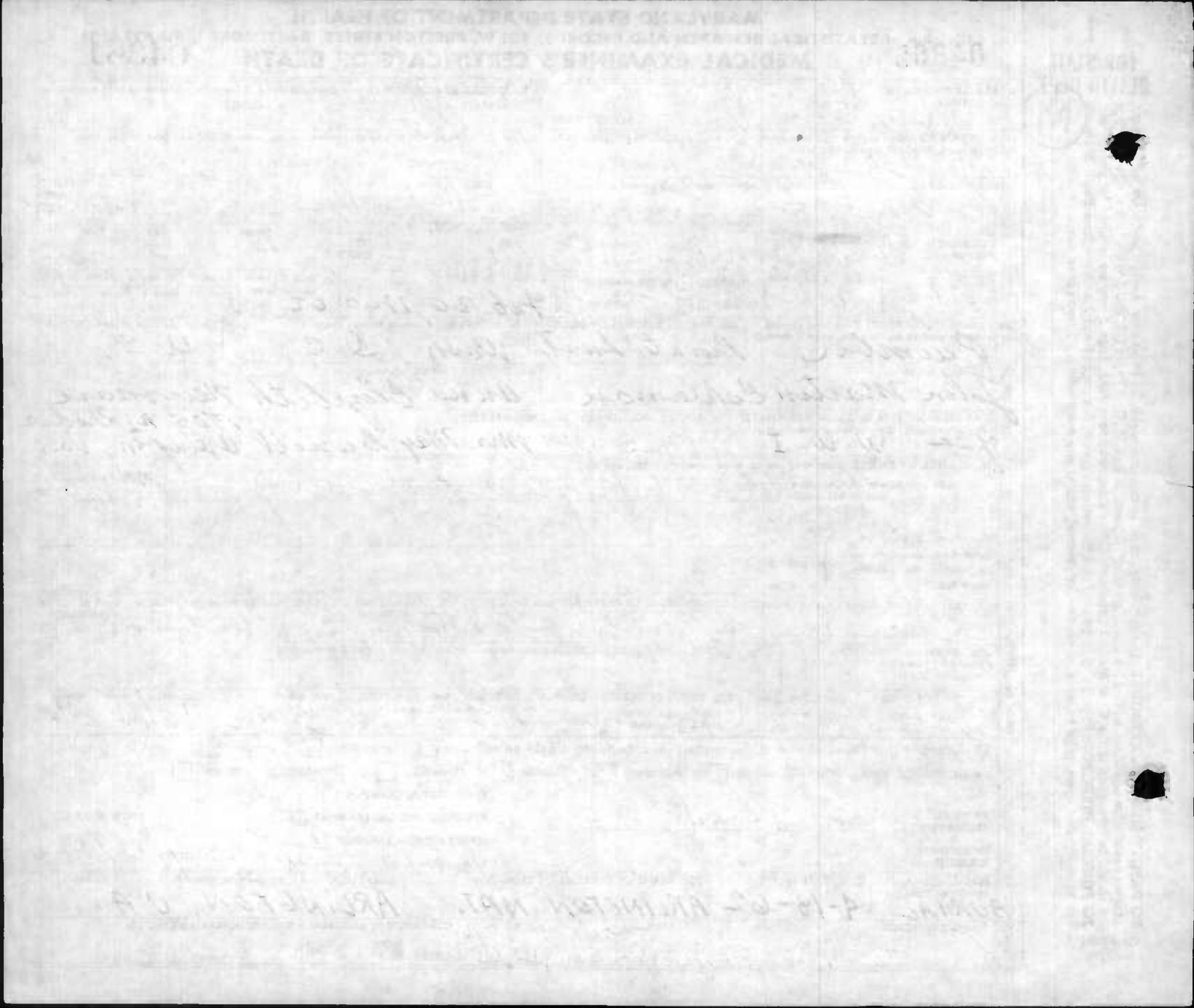
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04365

04361

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Salisbury W. Beach Murphy Apts		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
W. Beach		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
Irving		4514-44 th St NW Washington	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Erving Charles Eshleman		Month	Day
Middle		Year	
5. SEX		6. COLOR OR RACE	
M		W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb. 26, 1900 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Plumber		Private Bust.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Wash., D. C.		U. S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Martin Eshleman		Anna Elizabeth Neumann	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give awar or date of service)		17. INFORMANT	
Yes W.W. I		579-01-6365 Mrs. May Russell Arlington, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address, 505 N. Rhodes	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 7/3/62	
971.8 DUE TO		Alcohol & drug poisoning	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)			
} DUE TO			
} (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
There was an empty whisky bottle and 300 ml of gin.			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour a.m. p.m. 4/15/62		20c. (City or Town) (County) (State) W. Beach Calvert MD	
20d. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>		20e. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 4/15/62	
ACTUAL SIGNATURE H. W. Ward		DATE SIGNED	
EXAMINER'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF 4-18-62		22c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NAT.	
23. FUNERAL DIRECTOR Lee Funeral Home		22d. LOCATION (City, town, or country) (State) ADDRESS 300-4 ST NW ARLINGTON, VA. D.C. DATE APR 19 '62	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Tamm	





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FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of her death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04368

04362

1. PLACE OF DEATH o. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dowell		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First 5.	Middle Evans	Last April	4. DATE OF DEATH Month	Month 2	Day 1962
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 18, 1899	9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR Months —	IF UNDER 24 HRS. Days —	Hours —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William W. Evans		14. MOTHER'S MAIDEN NAME Annie Hall		Address Powell, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT William G. Evans		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion 420. J DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-10-1952 to 4-12-1962 , 1962 that (I) (we) last saw the deceased alive on 4-10-1962 and that death occurred at 12 p.m. from the causes and on the date stated above.							
22a. SIGNATURE J. Weems		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) C. J. Weems			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Removal Apr. 4, 1962		23b. DATE THEREOF Apr. 4, 1962		23c. NAME OF CEMETERY OR CREMATORIUM Ewell Cemetery		23d. LOCATION (City, town, or county) (State) Smith Island Md.	
24. FUNERAL DIRECTOR'S SIGNATURE G. A. Buckner & Son - Neutral, Md.		ADDRESS Neutral, Md.		25a. REC'D BY REGISTRAR DATE APR 4 '62		25b. REGISTRAR'S SIGNATURE Albert S. Kraus	

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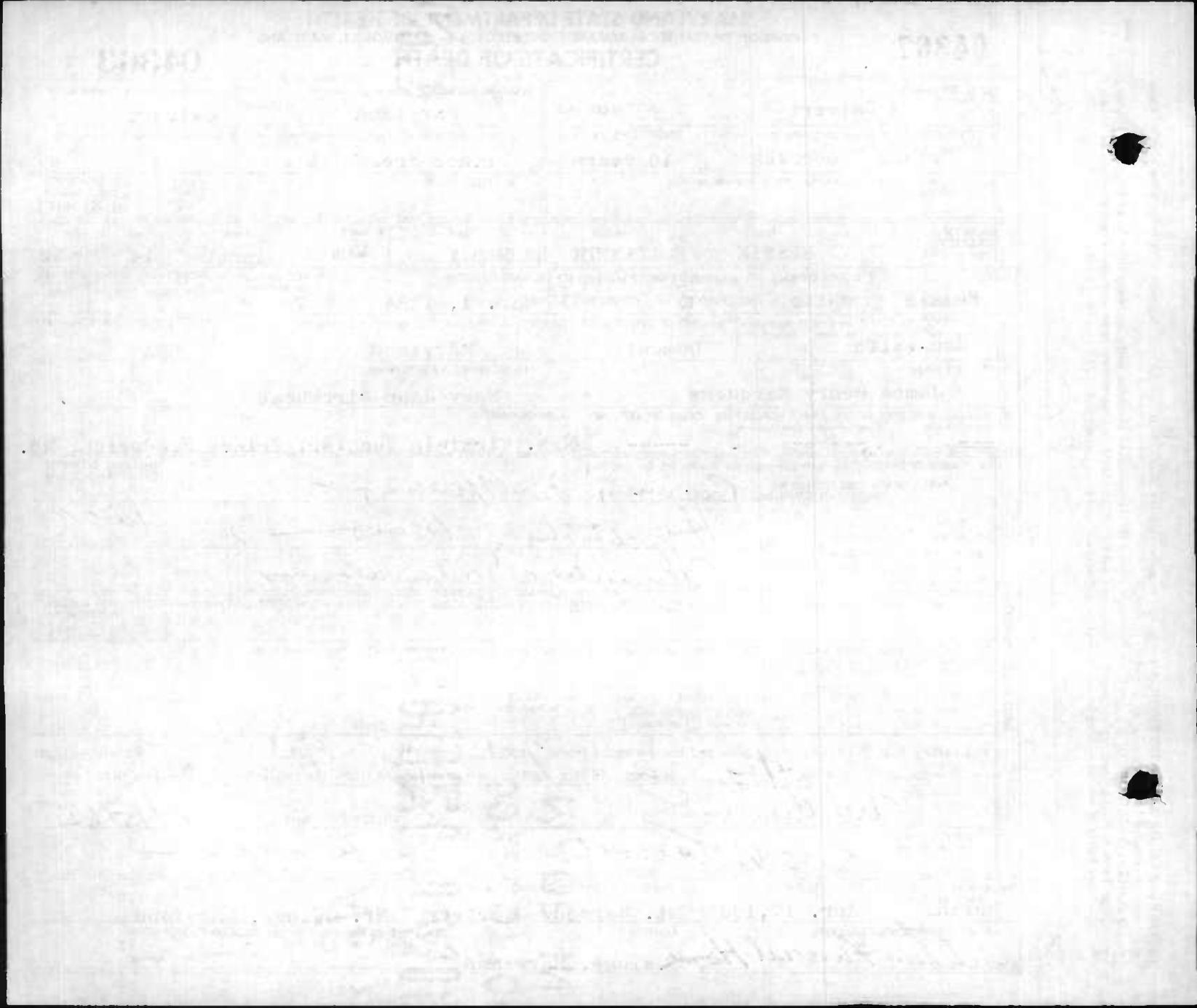
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04367

04363

1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 16 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick	
		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BESSIE		First ELIZABETH	Middle HARDESTY
Last		4. DATE OF DEATH April 14 1962	
S. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 1, 1884
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME James Henry Marquess		14. MOTHER'S MAIDEN NAME Mary Jane Birckhead	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----	17. INFORMANT Mrs. Virginia Buckler, Prince Frederick, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		<i>Cerebral Insufficiency - Hypertrophy of Brain }</i> 1 week	
(c)		<i>Generalized arteriosclerosis.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 7 1962 to April 17 1962 , that (I) (we) last saw the deceased alive on April 14 1962 , and that death occurred at 10 AM , from the causes and on the date stated above.		22b. DATE SIGNED 4/15/62	
22a. SIGNATURE <i>O. Williams</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS 54 Leonard
22c. PHYSICIAN'S NAME (Type) <i>R de Villarreal</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 17, 1962	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Harmony Cemetery
23d. LOCATION (City, town, or county) Nr. Owings, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Hutchinson Funeral Home</i>		ADDRESS Owings, Maryland	25a. REC'D BY REGISTRAR APR 18 '62
			25b. REGISTRAR'S SIGNATURE <i>J. Timm</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04368

Item 2 FILE G313

04364

1. PLACE OF DEATH
a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Huntingtown

c. LENGTH OF STAY IN lb

4 Years

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Leitch Manner

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Calvert Chas.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Huntingtown

La Plata

08 X 2

d. STREET ADDRESS

Leitch Manner

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

MARY

FLORENCE

First Middle Last

4. DATE
OF
DEATH

April 13,

Year
1962

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

September 18, 1868

9. AGE (In years
last birthday)

93

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

XXXXX

Berlin, Ind.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Thomas

14. MOTHER'S MAIDEN NAME

Frances M. Pursifull

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

86-98-7296

17. INFORMANT

Harden

Address

Billingsley Road
La Plata, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary heart disease

INTERVAL BETWEEN
ONSET AND DEATH

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Coronary heart disease

Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a. m.
p. m.

19

While at work Not while at work

20d. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20e. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 2-10 1962 to 4/13 1962, that (I) (we) lost
saw the deceased alive on 4/10 1962 and that death occurred at 8A.M. from the causes and on the date stated above.

22a. SIGNATURE

G. J. Weems, M.D.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
4/13/62

22c. PHYSICIAN'S
NAME (Type)

22d. ADDRESS

Huntingtown, Md

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

4/20/1962

23c. NAME OF CEMETERY OR CREMATORIUM

The Old Cemetery

23d. LOCATION (City, town, or county)

Columbus, Kansas

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Arehart Funeral Home, Inc.
Arehart Funeral Home, Inc. - La Plata, Maryland

25a. REC'D BY REGISTRAR
DATE APR 18 '62

25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04369

04365

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residencia before admission)	
<i>Cabret</i>		e. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barstow</i>	c. LENGTH OF STAY IN 1b <i>Life</i>	b. COUNTY <i>Cabret</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Barstow</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle
CONSTANCE HOFFMASTER HUTCHINS		Last	4. DATE OF DEATH
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH
<i>F</i>	<i>N</i>	<i>Sept. 14 1908</i>	9. AGE (In years last birthday) <i>53 yrs.</i>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Frederick Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>St. S. A.</i>	
13. FATHER'S NAME <i>Elaworth J. Hoffmaster</i>		14. MOTHER'S MAIDEN NAME <i>Alma Corbett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give grade and dates of service) <i>Reid Hutchins - Barstow - Cabret Co - Md.</i>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 416X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Rheumatic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		40 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from..... saw the deceased alive on..... and that death occurred at.....		1942, 19, to March, 19, 62 that (I) (we) last 3-18- 19, 62, and that death occurred at 7 a.m. from the causes and on the date stated above.	
22e. SIGNATURE <i>P. C. Jett</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>4-9-62</i>
22c. PHYSICIAN'S NAME (Type) Page C. Jett		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 11, 1962	23c. NAME OF CEMETERY OR CREMATORIUM Aubury Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE G.O. Warkness & Son - Mutual, Md.		23d. LOCATION (City, town or county) Barstow - Cabret Co - Md.	(State)
		ADDRESS Mutual, Md.	25a. REC'D BY REGISTRAR DATE APR 11 '62
			25b. REGISTRAR'S SIGNATURE Arthur S. Thane

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
to may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04370		04366	
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital	
d. STREET ADDRESS X Dowell		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Richard Johnson		First Middle Last	4. DATE OF DEATH April 8 19 62
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1876 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oysterman		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
10c. FATHER'S NAME Moses Johnson		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Elizabeth Johnson, Dowell, Maryland	
		Address Marie ?	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/20/61 DUE TO Arteria - CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized arterio-sclerotic disease (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/20/62 19 to 4/8/62 19, that (I) (we) last saw the deceased alive on 4/8 19, and that death occurred at 2:45 AM from the causes and on the date stated above.			
22a. SIGNATURE R. De VILLE REED		22b. DATE SIGNED 5th reward, Mr.	
22c. PHYSICIAN'S NAME (Type) R. De VILLE REED		22d. ADDRESS Lusby, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-10-62		23b. DATE THEREOF St. Johns	
		23c. NAME OF CEMETERY OR CREMATORIAL St. Johns	
24. FUNERAL DIRECTOR'S SIGNATURE Penkney E. Sewell, Prince Frederick		23d. LOCATION (City, town, or county) Lusby, Md	
		ADDRESS DATE APR 12 '62	
		25a. REC'D BY REGISTRAR John S. Thomas	
		25b. REGISTRAR'S SIGNATURE John S. Thomas	

39710

17730

financial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04367

1. PLACE OF DEATH a. COUNTY Calvert			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Prince Frederick Md.			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Prince Frederick, Md		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Julie	Middle A. Johnson	4. DATE OF DEATH April 17, 1962	Month Day Year
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1861	9. AGE (In years last birthday) 101 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Elizabeth Wallace		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Susie Johnson, Prince Frederick, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO — — GENERALIZED ARTERIOSCLEROSIS (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/16/62</u> , ta <u>4/17/62</u> , that (I) (we) last saw the deceased alive on <u>4/16/62</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Rodelline S</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>St. Herman</u>	
22c. PHYSICIAN'S NAME (Type) R de Villareal		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-19-62		23c. NAME OF CEMETERY OR CREMATORIAL Brooks		23d. LOCATION (City, town, or county) (State) Mutual, Calvert Md	
24. FUNERAL DIRECTOR'S SIGNATURE Binkley Sewell, Prince Frederick,		ADDRESS Md		25a. REC'D BY REGISTRAR APR 24 '62	
				25b. REGISTRAR'S SIGNATURE <u>Binkley Sewell</u>	

5860

PRINTED IN U.S.A. 1962

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04372

04368

CERTIFICATE OF DEATH

TO HOSPITAL: The law requires that the death certificate be executed within 2 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X St. Leonards</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert County Hospital</i>		d. STREET ADDRESS <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>THOMAS</i>	Middle <i>B. MACKALL</i>	Last <i>—</i>	4. DATE OF DEATH	Month <i>Apr.</i>	Day <i>5</i>	Year <i>1962</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 14, 1887</i>	9. AGE (In years last birthday) <i>75 yrs.</i>	IF UNDER 1 YEAR Months <i>—</i>	IF UNDER 24 HRS. Hours <i>—</i>	IF UNDER 24 HRS. Days <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Calvert Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John B. Mackall</i>		14. MOTHER'S MAIDEN NAME <i>Louisa J. Turner</i>		Address <i>Mrs Evelyn P. Mackall - St Leonards Rd</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-16-8272</i>		17. INFORMANT <i>CORONARY Occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		(b) <i>—</i>		(c) <i>—</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>St</i>	(County) <i>—</i>	(State) <i>—</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Mar. 14, 1957</i> , to <i>April 5, 1962</i> , that (I) (we) last saw the deceased alive on <i>Feb. 2, 1962</i> , and that death occurred at <i>—</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Pape & Jett</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>4/6/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>PAGE C. JETT</i>		22d. ADDRESS <i>PRINCE FREDERICK, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	23b. DATE THEREOF <i>Apr. 8, 1962</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Christ Church Cem. Port Republic, Md</i>	23d. LOCATION (City, town or county) <i>Port Republic, Md</i>	(State) <i>—</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Darkness & Son - Mutual, Md</i>		ADDRESS <i>—</i>	25a. REC'D BY REGISTRAR DATE <i>APR 9 '62</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Mulligan</i>			

01962

01962



TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04373

04369

1. PLACE OF DEATH o. COUNTY Calvert				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 1 day.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake Beach		d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Colin Maxwell	Middle	Last Maxwell	4. DATE OF DEATH April 10	Month April	Day 10	Year 1962		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1894		9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Doys 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner			10b. KIND OF BUSINESS OR INDUSTRY Coal		11. BIRTHPLACE (State or foreign country) Scotland					
13. FATHER'S NAME Robert Maxwell					14. MOTHER'S MAIDEN NAME Joanne McNeill					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 167-07-7320		17. INFORMANT Rebecca Maxwell, Chesapeake Beach, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Acute Heart Failure. Chronic Asthma Sleeplessness.										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year APR 9 1962	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chesapeake Beach	(County) Calvert	(State) Maryland				
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9:55 AM APR 10 1962 , and that death occurred at 9:55 AM , from the causes and on the date stated above.										22b. DATE SIGNED 4/10/62
22a. SIGNATURE Issam E. Damalouji, M.D.										22b. DATE SIGNED 4/10/62
22c. PHYSICIAN'S NAME (Type) Issam E. Damalouji, M. D.	M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/13/62	23c. NAME OF CEMETERY OR CREMATORIAL Lloyd Cemetery	23d. LOCATION (City, town, or county) Chesapeake Beach		(State) Penn.					
24. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home (Swings)	ADDRESS 100 Main Street	25a. REC'D BY REGISTRAR Cirthur S. Francis		DATE APR 13 '62	25b. REGISTRAR'S SIGNATURE Cirthur S. Francis					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04374		04370	
1. PLACE OF DEATH a. COUNTY Calvert M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Prince Frederick	
c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Nursing Home		d. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) ETTA Bush		First ETTA Middle Bush Last MILLER	4. DATE OF DEATH April 10, 1962
5. SEX Female 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug. 21, 1876		9. AGE (In years lost birthday) 85 yrs. IF UNDER 1 YEAR <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christian Bush		14. MOTHER'S MAIDEN NAME Henrietta Hodgkin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mr. Archie Duvall		Address -Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) THROMBOSIS DUE TO (c) Precious C.V.A. c THROMBOSIS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 19 _____, to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE Page C. Jett		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Page C. Jett		22d. ADDRESS Prince Frederick	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/13/62	
23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		23d. LOCATION (City, town, or county) Croom, (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home - Upper Marlboro		ADDRESS Md. 25a. REC'D BY REGISTRAR PR 24 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

30 Oct 1968

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04375

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04371

1. PLACE OF DEATH

a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Prince Frederick

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Calvert C. H.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Md

b. COUNTY

Calvert

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Barstow

Md

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First Middle

Last

4. DATE
OF
DEATH

Month
4

Day
7

Year
1962

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)
yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min.

WIDOWED

DIVORCED

Nov. 11 1944

17

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10b. KIND OF BUSINESS OR INDUSTRY

Maryland

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Helen Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

220-42-0335 Maggie Wallace, Barstow, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

981X

DUE TO

(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in part I or Part II of item 19.)

Was shot by foster fallen in self defense

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 6/17 1962

p.m.

20d. INJURY OCCURRED

While Not While

at work at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

House

20f. (City or town)

Barstow

(County)

Calvert

(State)

Md

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

Actual Signature

Examiner's Name (Type)

22a. (BURIAL) CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

4-21-62

22c. NAME OF CEMETERY OR CREMATORIAL

Carrolls

22d. LOCATION (City, town, or county)

Barstow,

Md

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

4/17/62

23. FUNERAL DIRECTOR

ADDRESS

Prince Frederick, Md

24e. REC'D BY REGISTRAR

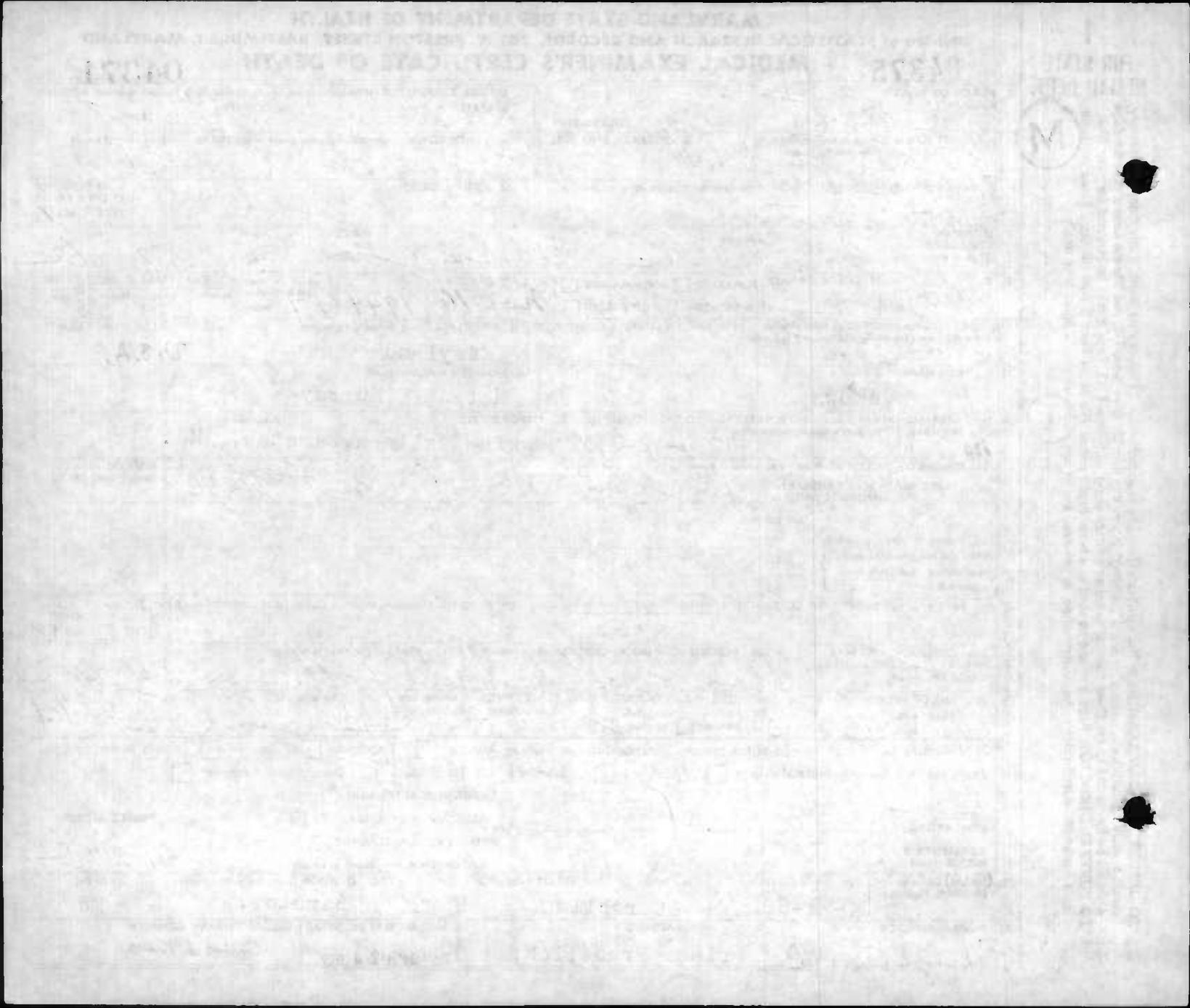
DATE APR 24 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Thorne

VS. A15ME
5M 7/59

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

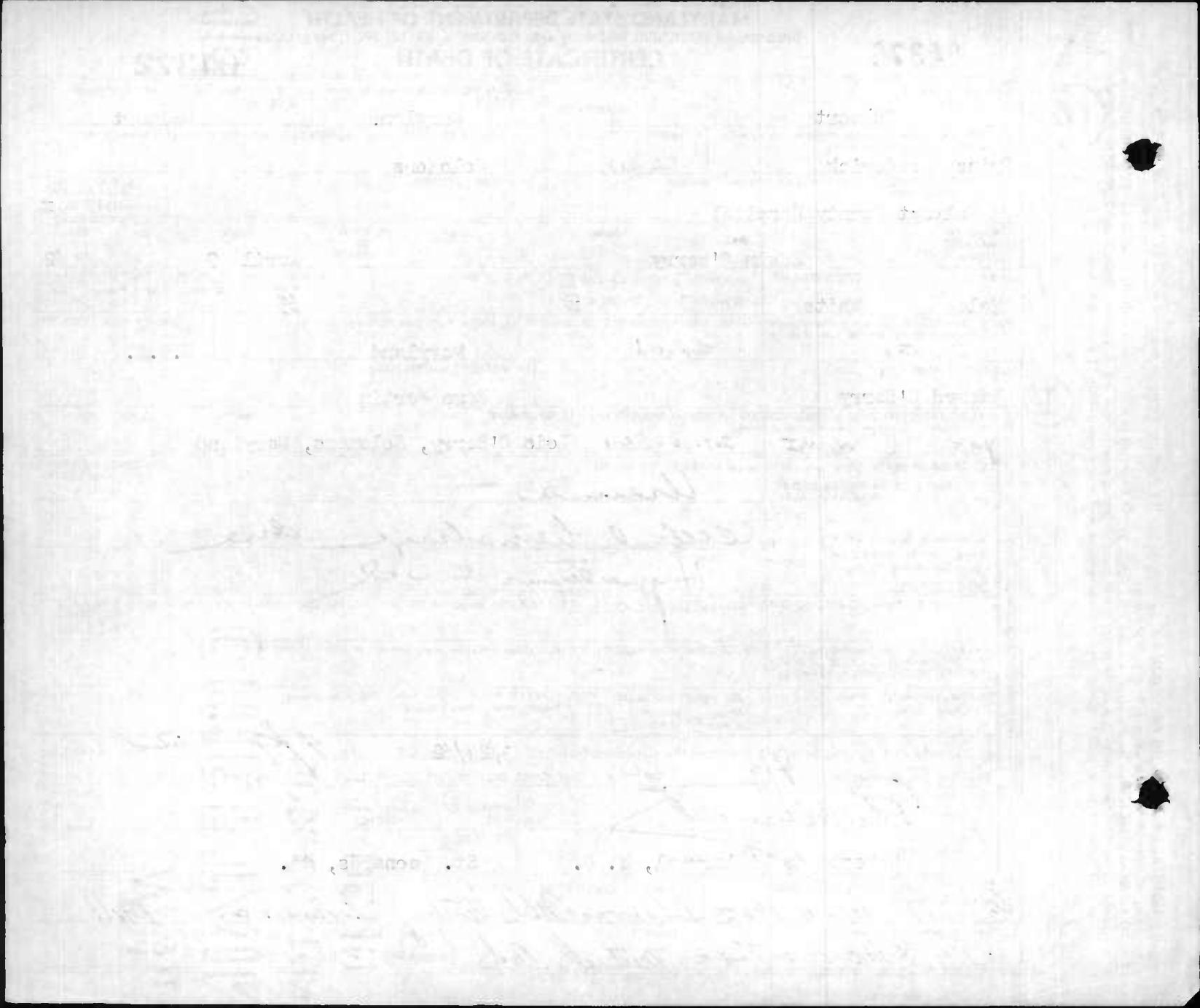
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04376		04372	
1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN lb 2 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edwin O'Berry		First M. Middle Last	4. DATE OF DEATH April 9 Month Day Year 19 62
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter.		10b. KIND OF BUSINESS OR INDUSTRY Ship yard	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward O'Berry		14. MOTHER'S MAIDEN NAME Emma Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. I 217-16-8301	
17. INFORMANT Lois O'Berry, Solomons, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Central hemorrhage due (c) DUE TO Hypertension C.vcl		Chronic.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/27/62 19 to 4/9 19 , that (I) (we) last saw the deceased alive on 3/27/62 19 , and that death occurred at M. from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE Roberto de Villarreal		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Roberto de Villarreal, M. D.		22d. ADDRESS St. Leonards, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 11, 1962	
23c. NAME OF CEMETERY OR CREMATORIAL Solomons Public Cemetery		23d. LOCATION (City, town, or county) Solomons Md.	
24. FUNERAL DIRECTOR'S SIGNATURE A. A. Hartness Son, Mutual, Md.		ADDRESS ADDRESS	
		25a. REC'D BY REGISTRAR APR 11 '62	
		25b. REGISTRAR'S SIGNATURE Albert S. Pirnia	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13
04377

04373

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach Prince Frederick		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North Beach			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Julius	Middle Elgin	Last Sherbert	4. DATE OF DEATH April 23	Month April	Day 23	Year 19 62
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/29/11	9. AGE (In years lost birthday) 50 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gasoline Station Owner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Owen E. Sherbert				14. MOTHER'S MAIDEN NAME Gertrude Crandall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-10-7929		17. INFORMANT Mrs. Thelma Sherbert, North Beach, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-10 1949 to 23 April 1962 , that (I) (we) last saw the deceased alive on 17/22 1962 and that death occurred at 24 M , from the causes and on the date stated above.							
22a. SIGNATURE G. J. Weems				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> G. J. Weems	MED. DIRECTOR <input type="checkbox"/> G. J. Weems	STAFF PHYS. <input type="checkbox"/> G. J. Weems	22b. DATE SIGNED 4/23/62
22c. PHYSICIAN'S NAME (Type) George J. Weems, M. D.				22d. ADDRESS Huntingtown, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 25, 1962		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion Cemetery		23d. LOCATION (City, town, or county) (State) Lothian Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home				ADDRESS Owings, Maryland		25a. REC'D BY REGISTRAR APR 27 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04378

04374

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)						
<i>Calvert</i>		a. STATE	b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
<i>Huntingtown</i>		<i>Huntingtown</i>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First	Middle					
<i>FLORENCE E. TYLER</i>								
4. DATE OF DEATH		Month	Day					
		<i>Apr. 28</i>	1962					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 84 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		
F		W		<i>Oct 3, 1877</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<i>Housewife</i>		<i>Home</i>		<i>Jefferson Co. Alabama</i>		<i>U.S.A.</i>		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes give rank or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT	Address
<i>James Edwin</i>		<i>Zoe</i>		<i>No</i>		<i>Unknown</i>	<i>Gladys F. Paddy - Huntingtown, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) / <i>Hypertension</i>		DUE TO <i>442 X</i>		INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.		(b)		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>5/1/1960 to 4/28/1962</i>	(County) <i>Huntingtown</i>	(State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>5/1/1960 to 4/28/1962</i> , that (I) (we) last saw the deceased alive on <i>4/28/1962</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.								
22a. SIGNATURE <i>Weems</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>4/29/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>G. J. WEEMS</i>		22d. ADDRESS <i>HUNTINGTOWN, MD</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr. 30, 1962</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Weedley Cemetery</i>		23d. LOCATION (City, town or county) <i>Ridge Frederick, Md.</i>		(State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>A. Q. Harkness & Son - Funeral Dir.</i>		ADDRESS		24e. REC'D BY REGISTRAR DATE <i>NAY 1 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Travis</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ESTATE OF

M